TOBACCO USER STATUS CHANGE REQUEST

I am requesting a change in my Tobacco User status.

☐ I certify that I and any of my dependents covered under my County medical insurance plan are not a Tobacco User and have not used any tobacco products in the last 6 consecutive months.

☐ I certify that:
- ☐ I am a Tobacco User
- ☐ My dependent(s) covered under my County medical insurance plan is a Tobacco User(s). Please fill in their name on the lines below:

Dependent 1	Dependent 3	Dependent 5
Dependent 2	Dependent 4	Dependent 6

I understand that a Tobacco User means the occasional or regular use of a tobacco product including cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco.

I certify to the best of my knowledge that the information I have provided is accurate, correct and complete. I understand that I may be subject to disciplinary action up to and including termination, for failing to provide accurate and complete information. I further understand and agree that I will be required to reimburse Maricopa County for any additional premiums owed as a result of providing inaccurate, incorrect and/or incomplete information.

Please indicate the date tobacco use ceased. *If you have never used tobacco indicate never in the date field.*	**Date:**
Print Employee Name:	**Date form completed:**
Employee Signature:	**Employee ID Number:** 811

Print this page, sign and return to the Employee Health Initiatives Department by fax, mail or in person.

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